

Commentary

The 'R' Word 'Rationing' of Health Care and the Role of Academic Health Centers

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These days, analysts are evaluating everything about American health care; the most au courant technique is called "outcomes" research, which aims at assessing how much good or ill results from the interventions under study. If an outcomes study could be made of the use of the word "rationing" with relation to health care, I think researchers would conclude the word's use has been a disaster and would recommend banning it from our health policy working vocabulary. That the use of the word "rationing" radiates more heat than light, more confusion and ambiguity than clarity and precision, and more fuzzy thinking than logical analysis was illustrated dramatically at a recent international conference on the rationing of technology in health care held in Los Angeles under the sponsorship of the International Society of Technology Assessment.

The conference itself was excellent and provocative; it attracted a series of first-rate speakers, policy experts, health care professionals, payers, and consumers. But there was no agreement on what rationing meant. One interpretation was that it refers to the rational and fair allocation of goods; another extended the definition of rationing by specifying that the goods to be allocated were in scarce supply. Tore Scherstén, a noted Swedish surgeon, presented a third view, defining rationing as the limiting of access by patients to valuable and efficacious interventions that are thought to be beneficial to them. Currently this sort of rationing is carried out bureaucratically in many countries, and in the United States, by the marketplace and patients' ability to pay. There was much discussion pro and con among the experts about the merits of the Oregon approach to a public, prospective setting of priorities for health care interventions, so as to guide funding decisions among competing interests in the event that allocated funds for health care were limited. David Banta, MD, a distinguished American pioneer in the field of technology assessment who has spent much of the past decade working in the Netherlands, worried aloud that efforts at health care cost control in the European community may be beginning to have the chilling effect of discouraging beneficial innovation across the board.

Payers at the conference pointed out once again the role of physicians in the overuse of technology, but major emphasis was also given to the role of the public in demanding health care of questionable usefulness. The participants understood the importance of cultural determinants to controlling costs in health care; Per Buch Andreasen, a highly respected Danish physician, rose to comment that it was mind-boggling for Europeans to observe firsthand the extraordinary American fixation on healthy life-styles, healthy and beautiful bodies,

and freedom from disease. Can we Americans learn to let go of life graciously, to die in season, and to resist the temptation to insist that every stone be turned to deliver to ourselves and our loved ones every last possible hour of life on this earth regardless of the enormous burden of increased, self-imposed suffering? Finally there was the difficult theme of physician control of the rationing process, with dissenting arguments coming from those physicians who feel deeply that the perception of their commitment to patients would be irretrievably damaged if patients were to think that physicians had the power to decide that, for whatever reason, a patient might not be worth saving with expensive intervention.

There was considerable discussion about the availability of care—the number of primary care physicians versus specialists, the presence or absence of gatekeepers—and what effect this has on the use of technology. The idea flickered across the stage that altering the proportion of primary care to specialist physicians might be the most effective approach to achieving a desired level of use of technology.

Only two things seemed to be widely agreed on by experts from the United States, United Kingdom, Denmark, Sweden, and the Netherlands:

- The escalating cost of health care across the western world mandates that choices be made and that unnecessary and inefficient interventions be scrapped;
- To make such choices rationally, more research and evaluation needs to be done on a continuing basis.

Even when and if the United States finds a financial plan through which to provide universal access to health care, the more serious task of figuring out what works and what does not will remain.

In 1984 Thurow and Fuchs, two of the nation's leading economists, wrote companion articles that clearly articulated these points.^{1,2} They both concluded that it would be best if physicians did not have to make choices to limit treatments that were proved effective, but both agreed that physicians must insist on having available better data about what works and what does not.

The recent release of the National Leadership Coalition's Report on Health Care Reform³ got widespread media attention but only on its admittedly extensive fiscal proposal and cost-control initiatives. No one seemed to take note of the major premise of the report that any approach to the so-called health care crisis needed to be systematic and not piecemeal. The media neglected to notice that, in addition to the financial dimensions of the report, there were other recommendations, including a section on quality, that if implemented

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would have perhaps the most far-reaching effect on our health care system. The National Leadership Coalition calls for a public-private commission that would determine, on the basis of the best available scientific evidence, which techniques work and therefore which ones will be paid for by either government or private health care dollars. This commission would also set priorities for research on unstudied interventions and techniques, allocating funds accordingly.

These recommendations are easier said than done. Yet the message is clear. If we want to make health care accessible to all, get the most for our money, and avoid a situation where we deny effective technologies to patients who need them, then we must develop the research required to evaluate the astounding health care technologies that will continue to spill from our research enterprises. If we can do a better job of ensuring the effectiveness and quality of that which is provided in our health system, there will be less of a need to use the "R" word and to argue about its definition.

If it is correct to establish an expanded and improved clinical evaluative research program as the linchpin of a more efficient and effective health care delivery system, then we have clearly laid a challenge at the doorstep of our nation's academic health science centers. There are several reasons why the academic community has not heretofore launched a more substantial health services research effort, including the following:

- There is not much money to support such research;
- No one gets tenure for doing multidisciplinary research, which many consider imprecise and inelegant and which frequently concludes that something does not work at all or well enough to warrant its use;
- The driving forces of our health industry have encouraged new technology without notable regard to cost.

Now, however, each of these forces has been countered, and there exist adequate incentives both outside of and within universities to facilitate their gearing up to do such research. There is a growing perception that a nation without better

data on which to base decisions about the need for new techniques and technologies will be a nation more likely to reduce its support for the scientific base that spins off the growing array of new interventions. If society cannot turn to its universities for this function, to what other institutions can it turn?

Universities can help solve resource allocation problems in at least two other ways. Society can be encouraged to accept and demand reasonable limits to health services. The university is the place where public attitudes are being researched regularly, and society would be receptive to university-initiated discussions of the issues surrounding medical care in the last year of life. Universities, through their academic health centers, can regularly convene conferences aimed at educating professions and laity alike about the issues and options surrounding the health care reform debate. If it is true that our national debate has just begun, then we must strive to achieve as high a degree of public understanding of health-related matters as possible. Such an effort should most naturally be led by universities and their academic health centers.

Entering the next phase of the national health care policy debate perseverating over the word "rationing," with all its meanings, symbolic and real, will be unproductive and confusing to the public. On the other hand, arguing about how best to ensure and improve the effectiveness and quality of our techniques and technologies and, on a parallel track, discussing the best methods of determining how much we are willing to pay as a society for health care will constructively orient the debate so that citizens of good will can move together towards selecting societal programs that best meet our needs. This is what the National Leadership Coalition's much-heralded report has contributed, if we are willing to listen to its message.

REFERENCES

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2. Fuchs V: 'Rationing' of medical care. *N Engl J Med* 1984; 311:1572
3. Excellent Health Care for All Americans at a Reasonable Cost. Washington, DC, Report of the National Leadership Coalition for Health Care Reform, 1991